STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150038	A. BUILDING _____ B. WING _____	12/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH MORGAN HOSPITAL I	2209 JOHN R WOODEN DR MARTINSVILLE, IN 46151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of 1 (one) State hospital complaint investigation. Complaint: #IN00091814 Substantiated; no deficiencies cited related to the allegations. Facility: #005036 Date: 12-1-2011 Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor Indiana University Health Morgan Hospital, Inc. is in compliance with 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing services, 410 IAC 15-1.6.5, Psychiatric services, 410 IAC 15-1.5-10, Utilization review and discharge planning services, and 410 IAC 15-1.5-4, Medical records services, Indiana State Hospital Licensure Rules. QA: claughlin 02/14/12	S 000		